STATE OF DELAWARE
Child Death, Near Death and Stillbirth Commission
900 King Street, Suite 220
Wilmington, DE 19801-3341

CAPTA[1] REPORT

In the Matter of
Steven Holmes
Minor Child[2]

9-02-2009-00026

May 7, 2010

[1] The federal Child Abuse Prevention and Treatment Act requires the disclosure of facts and circumstances related to a child's near death or death. 42 U.S.C § 5106 a(b)(2)(A)(x). See also, 31 Del.C. § 323 (a).
[2] To protect the confidentiality of the family, case workers, and other child protection professionals, pseudonyms have been assigned.

Background and Acknowledgements

The Child Death, Near Death and Stillbirth Commission ("CDNDSC") was statutorily created in 1995 after a pilot project showed the effectiveness of such a review process for preventing future child deaths. The mission of CDNDSC is to safeguard the health and safety of all Delaware children as set forth in 31 Del.C., Ch., 3.

Multi-disciplinary Review Panels meet monthly and conduct a retrospective review of the history and circumstances surrounding each child's death or near death and determine whether system recommendations are necessary to prevent future deaths or near deaths. The process brings professionals and experts from a variety of disciplines together to conduct in-depth case reviews, create multi-faceted recommendations to improve systems and encourage interagency collaboration to end the mortality of children in Delaware.

Summary of Incident

The case regarding Steven Holmes is considered a near death incident due to the physical neglect that was perpetrated by his biological parents. At the time of the near death, Steven was approximately 28 days old. The child was admitted to the hospital due to severe failure to thrive of a non-organic nature. It was determined by medical personnel that adequate care of this child's physical and emotional needs were not being met by the child's parents, thus resulting in a lack of physical development with the primary concern being the child's lack of weight gain.

The child was born at 36 weeks gestation weighing 3 pounds and 11 ounces, which was small for gestational age. The child was transferred to another hospital, following his birth, and remained in the hospital's Neonatal Intensive Care Unit for eleven days due to temperature instability and hypoglycemia. The child was discharged at 4 pounds 6 ounces into the care of his parents. It was noted by the child's physician that a higher level of care would be required due to the child's prematurity. Moreover, at this point in time, it was noted that the child's mother suffered from epilepsy and experienced uncontrolled seizures three to four times a week. These seizures usually resulted in the mother being unresponsive for ten to twenty minutes at a time. Therefore, the level of care that the mother would be able to provide to the child was called into question. As was standard for every infant discharged from the Neonatal Intensive Care Unit, a referral for home nursing care was made and implemented upon the child's discharge. This referral consisted of a nurse visiting the home twice a week for two weeks. Documentation by the nurse, from these visits indicated that the child remained small with very little body fat and that the mother was mixing the child's formula improperly. The nurse instructed the mother on the proper mixing of the formula and encouraged the mother to call the child's primary care physician for an appointment regarding concern over the child's lack of weight gain.

The child was seen by a family physician 3 days after discharge from the hospital. At this visit the child was noted to have lost 5 ounces, weighing 4 pounds and 1 ounce, and the child was diagnosed with gastroesophageal reflux. At a follow-up appointment, approximately 6 days later, the child had only gained 2 ounces and was diagnosed with failure to thrive, then weighing 4 pounds and 3 ounces. Finally, 8 days later the family

physician saw the child again and noted that the child had lost one ounce since his previous visit.

The child was subsequently admitted to the hospital 20 days after discharge for weighing only 4 pounds and 2 ounces. According to the pediatrician, upon admission, the child was in a critical state of failure to thrive and there was no medical reason for the child's condition. Hospital staff expressed concern with the parents' ability to care for the child. A lack of bonding and interaction was also observed between the parents and the child by hospital staff. During the child's hospitalization, hospital staff reported that the parents were neglectful of the child's care and feedings. Specifically, hospital staff had to wake the parents and stay with them in order to ensure that the child was being fed properly.

Due to the failure to thrive diagnosis and the parents' neglectful care of Steven, the Division of Family Services ("Division") obtained custody upon discharge of Steven from the hospital. The Division substantiated the child's mother and father for neglect, level III on the Child Abuse Registry. No criminal charges were filed due to the significant cognitive limitations of both the parents. However, there was significant delay by the Division in reporting this neglect case to police as required by the Memorandum of Understanding between the Department of Services for Children, Youth and Their Families, Delaware's Children's Advocacy Center, Department of Justice, and Delaware Police Departments. After significant reunification efforts were exhausted the child was adopted.

System Recommendations

The following recommendation was put forth by the Commission:

(1) CDNDSC recommends that the use of Electronic Information Sharing and further enhancements of such systems be implemented and used by all medical professionals in order to help track hospital re-admission rates for premature babies who are discharged prior to weighing 5 pounds.
    a. Rationale: Steven was discharged weighing less than 5 pounds to two cognitively delayed parents. Although Steven only presented to the emergency room once after birth, the child presented to his primary care physician several times within a matter of days. Standard of care would suggest that the child be seen more frequently given the diagnosis of non-organic failure to thrive, and the fact that the child continued to lose weight after each visit with the primary care physician. Furthermore, it is evident that the child's parents had limitations and therefore it is questionable as to whether further assistance was needed by the parents in order for them to adequately care for their child. If proper tracking and assessment of the child's history had been conducted, necessary intervention might have been provided and the child's diagnosis of failure to thrive might have been prevented. Additionally, current practice allows for discharge after 4 pounds. Statistics should be collected to ensure that this discharge protocol is not increasing the risk of serious injury or failure to thrive of premature infants.

b. Anticipated result: To establish a uniform medical tracking system so that all medical personnel are aware of the child's history upon admission.
c. Responsible Agency: Health Care Commission

Ancillary Factors[3]

The following ancillary factors were identified and will be evaluated by CDNDSC for possible action:

(1) The Division of Family Services shall adhere to the Memorandum of Understanding between the Department of Services for Children, Youth and Their Families, Delaware's Children's Advocacy Center, Department of Justice, and Delaware Police Departments with regard to referring cases of neglect to law enforcement.
   a. Rationale: Cases of neglect do not always invoke a criminal response and therefore are often less likely to be reported. However, since serious injury can occur from neglect it is imperative that adherence to the Memorandum of Understanding be followed and cases such as this be reported to the appropriate agency.
   b. Anticipated Result: To create awareness and raise the level of recognition of each agency's responsibility and that of the lay public for reporting cases of suspected child abuse and neglect.
   c. Responsible Agency: Department of Justice

[3] In some cases there may be no system practices or conditions that impacted the death or near death of the child; however, if the Panel determines that there are ancillary factors which impact the safety or mortality of children, those factors are compiled by CDNDSC staff and presented at least annually to the Commission for possible action.